Correspondence

The Editors will be pleased to receive and consider for publication correspondence containing information of interest to physicians or commenting on issues of the day. Letters ordinarily should not exceed 600 words and must be typewritten, double-spaced, and submitted in duplicate (the original typescript and one copy). Authors will be given the opportunity to review the editing of their correspondence before publication.

The Peer Review Process

To THE EDITOR: The article by Dippe and colleagues in the July issue[1] is misleading about the practice of peer review under the Peer Review Organization (PRO) program and inaccurately characterizes how PROs review for necessity of admission to hospital, with the attendant risk of fostering the belief that PROs are big brothers following a mythical set of ironclad rules. A review of how PROs actually evaluate the necessity of an admission should help to correct any misunderstandings.

First, the article inaccurately describes how criteria are used. Nurse reviewers indeed use the InterQual "Severity of Illness" and "Intensity of Service" criteria but only as screens to identify possibly unnecessary admissions. The authors state, "Admission of a Medicare patient can be denied if the patient does not meet both [of the criteria]." This implies an admission must "meet" criteria to be approved. In fact, quite the opposite is true: an admission must substantially fail all criteria to be considered a possibly unnecessary admission.

When an admission fails all criteria, it is then referred by the nurse to a physician for review. It is key to understand that the physician reviewing the case does not use "criteria" at this point. He or she must use clinical judgment. The physician's task is to answer this question: Was it prudent, necessary, and appropriate to admit the patient at that point in time to the hospital? If the answer is yes, the admission is approved. It is also important to understand that any physician who reviews Medicare cases for a PRO is, by federal mandate, a licensed, actively practicing physician. The PRO program represents true peer review.

There also seems to be misunderstanding about when a denial is final. A single physician does not determine a final denial, as could be inferred from the article. The first physician reviewer's concern leads to a notice of a proposed admission denial, to which both the hospital and the attending physician may respond. If either party responds, a second, independent physician reviewer then reviews the chart, as well as any arguments the attending physician and hospital may make to justify the admission. Only if the second physician reviewer concurs is the denial notice issued. While this is technically called a final denial, the hospital, the attending physician, and in most cases the patient have yet another opportunity (the reconsideration process) to present information that may justify the admission. Thus, three physicians—and in some cases, even more—must independently agree that an admission was unnecessary before there is no further recourse with the PRO.

The peer review process is subjective, and it is unlikely that this will ever cease to be the case. But clinical medicine is also subjective, and it is far from clear that subjectivity is a problem in the peer review program. Indeed, it may well be one of the best features in that it increases discussion and consideration among peers. The peer review process may be imperfect, but I submit that PRO practices in 1989 are substantially more equitable than those described in this study of 1986 cases.

BRUCE A. MANN, MD
New Mexico Medical Review Association
Box 9900
Albuquerque, NM 87119-9900

REFERENCE

1. Dippe SE, Bell MM, Wells MA, et al: A peer review of a peer review organization. West J Med 1989; 151:93-96

* * *

Drs Dippe and Bell Respond

To THE EDITOR: Before responding to the letter by Dr Mann, a few comments are needed. The tone of Dr Mann's letter suggests that our article was meant to criticize peer review organizations. We believe that PROs in general try to be fair and equitable, that the reviewers hired by the PROs are themselves interested in maintaining high quality of care. In addition, we believe that our own peer review organization, the Health Services Advisory Group, also tries its best to maintain high quality peer review.

Clearly, the Medicare criteria are *not* ironclad rules, and we did not interpret it that way in our study. The criteria are stipulated, however, and are read by the reviewers. How those criteria are applied to each individual case varies with the independent reviewer. It would be foolish to assume that the criteria are interpreted equally by all the reviewers, and it would be equally foolish to assume that the criteria are fixed in stone. We did not state that Medicare admissions would be denied if they did not meet the criteria, rather that nurse reviewers could forward the case to a physician reviewer for a decision if the case did not meet the criteria.

Unfortunately, Dr Mann stated our premise incorrectly as it relates to the final disposition of denial. We clearly state that in 1986 the physician was given the opportunity to explain the reason for the patient admission, and if the explanation was adequate, the admission was approved. Even if the denial took place, it could be overturned successfully. Also, we would have to agree with Dr Mann that the process of review has not only changed but has improved.

Finally, we interpret a sense of hostility—or perhaps frustration—in Dr Mann's letter. We apologize if we have offended anyone involved in the review process; however, we believe the goals set by Dr Mann and ourselves are indeed similar. We want the best possible care given to our elderly, and peer review organizations should try their utmost to ensure high quality care and at the same time reduce unnecessary admissions.

STEPHEN ERIC DIPPE, MD
MARVIN MOE BELL, MD
7301 E Fourth St, Suite 22
Scottsdale, AZ 85251